Policy and Sustainability Committee

10:00am, Tuesday, 30 November 2021

Duty of Candour

Executive/routine
Wards
Council Commitments

1. Recommendations

1.1 Note the content of the attached Council policy, procedure and accompanying documentation.

1.2 Approve the Council Duty of Candour Policy, which is underpinned by the Scottish Government's The Duty of Candour Procedure (Scotland) Regulations 2018 which are provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act).

1.3 Acknowledge that the Council has a collective legal duty as the **Responsible Person** to act appropriately and with honesty and openness in the event of unintended harm caused during the delivery of health, care or social work services.

1.4 Understand that the Council's approach to its duty of candour responsibilities are central to providing safe, responsible and accountable public services.

Julien Kramer

Interim Executive Director for Education and Children's Services

Contact: Jon Ferrer, Senior Manager, Quality, Governance and Regulation

E-mail: jon.ferrer@edinburgh.gov.uk | Tel: 0131 553 8396

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THE CITY OF EDINBURGH COUNCIL

Report

Duty of Candour

2. Executive Summary

2.1 It is understood that when unintentional harm occurs to a user of a service, the act of corporate accountability and timely apology is the best restorative approach to effectively focus on repairing the harm that has been done. This report highlights the Council's responsibility as a local authority and **Responsible Person** within its duty of candour responsibilities as set out by the Scottish Government. The Council is required to develop and maintain local procedures, processes and systems for recording and reporting, managing, and responding to an unintended incident that has caused harm, serious harm, or death of a person. This report also highlights, where appropriate, agency, leadership and management arrangements required when the duty of candour procedure is instigated.

3. Background

3.1 The aim of the Scottish Government's duty of candour legislation is to ensure that all organisations providing health, care and social work services exact their duty of care and notify those affected by an unintended or unexpected incident when they occur.

3.2 The Scottish Government require all organisations to adopt good practice standards that are person-centred and promote safe environments that reduce barriers to effective organisational responses when things do go wrong.

3.3 The aim of duty of candour is to provide a consistent standard of practice and outcomes across health, care and social work services. This provides continuity of care and is consistent with professional standards and codes of practice for professionally registered staff.

4. Main report

4.1 Organisations that provide a health service, care service and/or social work service must adopt the relevant legislation which the duty of candour applies. This is set out in section 25 of the Act. For the Council this is its role as a 'local authority'. Equally, the Council contracts services from a great deal of providers of care and

individually, these contractors must ensure the implementation of their responsibilities as a **Responsible Person** with duty of candour.

4.2 The Council must activate the duty of candour procedure after they become aware an unintended or unexpected incident has occurred whilst carrying out a health, care or social work-related service, and where the outcome (below) relates directly or can be attributed to, considering the natural course of a person's illness or condition, one or more of the following categories[1]:

4.2.1 The death of a person.

4.2.2 Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions ("severe harm").

4.2.3 Harm which is not "severe harm" but which results in significant impairment or shortens life expectancy.

4.2.4 The person requires treatment by a registered health professional in order to prevent any of the above or death.

4.3 The decision to activate the duty of candour **must** be taken in conjunction with the **Duty of Candour Panel**, whose membership is made up of the relevant Director of the service, Chief Social Work Officer and the NHS Medical Director who has a delegated responsibility by the Scottish government for the assessment of outcomes (4.2) as the **Registered Health Professional**. The Registered Health Professional has the responsibility to assess for the outcomes as detailed in 4.2.

4.4 Registered care services have a responsibility to report duty of candour instances to the Care Inspectorate.

4.5 Duty of candour places organisational responsibility on the Council to engage in a purposeful and meaningful apology, effective communication with the person affected by an unintended event that has caused harm (and/or their family) and to provide support to employees and others who may be affected by the incident(s).

4.6 The Council's duty of candour Policy and Procedure does not replace those already implemented within the Edinburgh Health and Social Care Partnership (EHSCP). Alignment with pathways developed by EHSCP were agreed at point of design.

4.7 This Policy and Procedure includes Children's services and services provided by Community Justice.

5. Next Steps

5.1 Development of a communications strategy both internally and externally that includes members of the public regarding their rights when receiving services.

5.2 Review and update subject-related policy and procedure.

5.3 Inclusion within quality assurance and improvement activity.

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[1] As defined by Scottish Government, Organisational duty of candour guidance, 2018

6. Financial impact

6.1 The implementation of duty of candour helps positively shape culture and practice. It can also mitigate risk with earlier resolution of complaints against a service, overall reducing the financial impact that can arise from liability claims against the Council.

6.2 There is no direct financial cost to implementing the policy and procedure. There is indirect staffing requirement to support the implementation.

7. Stakeholder/Community Impact

7.1 The Duty of Candour policy and procedure applies to incidents that the Council becomes aware of after 1 April 2018. Duty of candour procedure can be instigated for events that occurred before the implementation date if the Council were made aware of the event after 1 April 2018.

8. Background reading/external references

8.1 None.

9. Appendices

9.1 Appendix 1 - Duty of Candour Policy

9.2 Appendix 2 - Duty of Candour Procedure

Duty of Candour

Implementation date [date policy comes into force as this may differ from approval date]

Control schedule

Version control

Approved by		Name of Committee	
Version	**Date**	**Author**	**Comment**
0.1	**20/01/20**	**Wendy Henderson**	
0.2	**10/03/20**	**Wendy Henderson**	
0.3	**06/10/20**	**Jon Ferrer**	
0.4	**26/05/21**	**Jon Ferrer**	

Subsequent committee decisions affecting this policy

Date	Committee	Link to report	Link to minute

1. Policy statement

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (the Act) introduced a new organisational Duty of Candour on health, care and social work services. The procedure to be followed is set out in the Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) and came into effect on 1 April 2018.

Enabling and managing risk is a central part of delivering high quality health, care and social work services. The Duty of Candour promotes responsibility for developing safer systems, better engages staff in improving services and creates trust in people who use our services.

2. Scope

The Duty of Candour procedure must be carried out by the responsible person (the Council) as soon as reasonably practicable after becoming aware that an individual who has received a health, care, or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in, or could result in:

- the death of the person;
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions;
- an increase in the person's treatment;
- changes to the structure of the person's body;
- the shortening of the life expectancy of the person;
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days;
- the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days;
- the person requiring treatment by a registered health professional in order to prevent:
    - the death of the person; or
    - any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.

The Duty of Candour policy and procedure applies to incidents that the responsible person becomes aware of after 1 April 2018. For example, after 1 April 2018, if the responsible person (the Council) becomes aware of unexpected

psychological harm that occurred because of care provided to the relevant person in 2015, the Duty of Candour procedure should be activated.

The responsible person (the Council) will become aware of incidents through existing Council procedures as detailed below and in the associated Duty of Candour procedures, process map and documentation.

The overall purpose of the Duty of Candour is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act.

The Act defines the "responsible person" as:

- a Health Board
- a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service
- the Common Services Agency for the Scottish Health Service
- a person (other than an individual) providing an independent healthcare service
- **a local authority**
- a person (other than an individual) who provides a care service
- an individual who provides a care service and who employs, or has otherwise made arrangements with, other persons to assist with the provision of that service
- a person (other than an individual) who provides a social work service

This means that the Duty of Candour applies to the Council and not individuals.

The responsible person (the Council) is responsible for:

- Carrying out the Duty of Candour procedure when activated
- Undertaking training required by regulations
- Providing training, supervision and support to any person carrying out any part of the procedure as required under regulation
- Reporting annually on the duty

3. Definitions

Responsible Person – every organisation covered by the Duty of Candour legislation is regarded as a “responsible person” within the definition as set out in Section 25 of the Act.

Relevant Person – is the person who has been harmed during the incident. If this person lacks capacity or otherwise unable to make a decision (i.e. if the person has died) about the service provided, it is the person acting on their behalf (see section 22(3) of the Act).

Registered Health Professional - a member of a profession to which section 60(2) of the Health Act 1999 applies.

Lead Officer – the person appointed to undertake the Duty of Candour investigation. This could be the officer appointed to undertake the investigation into the

incident/complaint before the decision to activate the Duty of Candour is taken by the Nominated Health Professional.

4. Policy content

4.1 Incident which activates the duty:
The Duty of Candour procedure must be carried out by the responsible person as soon as reasonably practicable after becoming aware that an individual who has received a health, care, or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional (Tracey Gillies, NHS Lothian Medical Health Director) has resulted in, or could result in:

- the death of the person;
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions;
- an increase in the person's treatment;
- changes to the structure of the person's body;
- the shortening of the life expectancy of the person;
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days;
- the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days;
- the person requiring treatment by a registered health professional in order to prevent:
    - the death of the person; or
    - any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.

4.2 The Duty of Candour Procedure (the Procedure)
The 'Duty of Candour Procedure' means the actions to be taken by the responsible person in accordance with regulations made by the Scottish Ministers. The regulations detail the specific actions and recording of information required by the responsible person when carrying out each stage of the procedure and are set out in regulations 2 to 7 of the Duty of Candour Procedure (Scotland) Regulations 2018.

The key stages of the procedure include:

a. notify the person affected (or family/relative where appropriate)
b. to provide an apology
c. to carry out a review into the circumstances leading to the incident
d. to offer and arrange a meeting with the person affected and/or their family, where appropriate
e. to provide the person affected with an account of the incident
f. to provide information about further steps taken
g. to make available, or provide information about, support to persons affected by the incident
h. to prepare and publish an annual report on the Duty of Candour

4.3 Making an apology

For the purposes of the Act, an "apology" means a statement of sorrow or regret in respect of the unintended or unexpected incident that caused harm or death. The Act sets out that an apology or other step taken in accordance with the Duty of Candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty.

The Act states that the responsibility for the apology rests with the responsible person (the Council) and that within each organisation there will be individuals with delegated responsibility for ensuring that an apology is provided on behalf of the organisation. The Council has delegated this responsibility to the Lead Officer appointed to conduct the formal investigation into the incident when the Duty of Candour has been activated.

The apology should be based on individual circumstances, there is no “one size fits all” apology.

The Four Rs are an easy way to remember how we can get this right:

1. **Reflect** – stop and think about the situation
2. **Regret** – give a sincere and meaningful apology
3. **Reason** – if you know, explain why something has happened or not happened and if you don't know, say that you will find out
4. **Remedy** – what actions you are going to take to ensure that this won't happen again and that the organisation learns from the incident

By making an apology following an unintended or unexpected incident, the Council is acknowledging that harm has been caused, a mistake has been made and that the Council is acknowledging emotions that are felt by the relevant person(s). A meaningful apology can help to calm a person who has become angry or upset. An apology is not an admission of liability.

4.4 The Relevant person: Adults with incapacity and following a death

In carrying out the Duty of Candour procedure it is for the Council, in their role as responsible person, to determine who should act on behalf of a relevant person who lacks capacity or who has died, taking into account any existing arrangements that are in place with regard to power of attorney or guardianship and seek legal advice as appropriate.

4.5 Training, Education, Advice, Guidance and Publicity

Resources have been allocated by NHS Education for Scotland and the Scottish Social Services Council to support training and awareness and have made Duty of Candour training and education available through existing networks and communication channels. Using and targeting existing resources will also be an important element of implementation and support for the Duty of Candour.

The Council is asked to support a range of approaches with regard the planning, delivery and continuous improvement of their processes when applying the Duty of Candour procedure.

5. Implementation

This policy is supported by a Duty of Candour procedure, process map and links to relevant supporting documentation.

A communications programme will be developed to support awareness and understanding once the policy, procedure and associated documentation has been signed off.

In line with legal requirements, the Council will publish the Duty of Candour report in the Chief Social Work Officer's annual report, including lessons learned and actions taken.

The lessons learned and actions taken will influence and inform the annual review of the policy, procedures and associated documentation.

6. Roles and Responsibilities

It is the responsibility of managers of services registered with the Care Inspectorate and managers of social care services to follow the Regulated Services Compulsory Reporting Policy and Procedures.

This will ensure that the Provider of the Service, the Council, complies with regulatory reporting requirements and result in notifications being sent to:

1. The Care Inspectorate
2. The Provider's Health and Safety Team
3. The Chief Social Work Officer
4. Social Care Direct – if applicable

Registered managers and managers of social care services must complete and submit their notification of Duty of Candour within 24 hours of them becoming aware or of the incident occurring.

Related documents

Nursing and Midwifery Council/General Medical Council Openness and honesty when things go wrong: the professional Duty of Candour

Scottish Public Services Ombudsman Meaningful Apologies

Scottish Public Services Ombudsman Model Complaints Handling Procedure Model Complaints Handling Procedure

The Knowledge Network NHS Little Things Make a Big Difference (including fact sheet and e-learning module)

The Professional Association for Social Work and Social Workers Building a Culture of Candour

The Scottish Government Duty of Candour: Frequently Asked Questions

The Scottish Government Duty of Candour Health Care Standards

Integrated impact assessment

This policy and associated procedure evidence the Council's commitment to advancing the equality of opportunity to good life outcomes for people with the following protected characteristics:

- Age (both younger and older people)
- Disability (physical, learning, mental health and other lifelong conditions covered by the Equality Act 2010)

In addition, the implementation of this policy will enhance the right to life and the right to health for people currently using the services and those who will use the services in the future.

Risk assessment

The risks associated with noncompliance with this policy by the Council would contravene the legal requirements placed on it by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) which came into effect on 1 April 2018.

In adopting this policy, the Council will be able to comply with regulatory requirements regarding an annual report detailing what actions have been taken, what lessons have been learned and actions taken which influence and inform the annual review of the policy, procedures and associated documentation.

Review

This policy will be reviewed annually and presented to the Policy and Sustainability committee.

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YOUR COUNCIL – YOUR SERVICES

Procedure Title - Duty of Candour

Management Information		
Lead Officer	**Name:**	Jon Ferrer
	Designation:	Senior Manager Quality, Governance and Regulation
	Tel:	0131 553 8396
Lead Service Area	Quality Compliance and Regulation	
Date Agreed	<<e.g. 01 January 2012>>	
Last Review Date	<<If applicable>> <<e.g. 01 January 2012>>	
Next Review Date	<<e.g. 01 January 2012 = press F1 key for help>>	
Agreed by	Safer and Stronger Communities	
Has Screening for Equality Impact been undertaken for this procedure?	Yes/No: *(please specify)* Date <<e.g. 01 January 2012>>	
Has Implementation and Monitoring been considered for this procedure?	Yes/No: *(please specify)* Date <<e.g. 01 January 2012>>	
If appropriate, has Health and Safety section had oversight of this procedure? **Name of Health and Safety contact**	Yes/No: *(please specify)* Date 10 November 2019	

1. PURPOSE

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (the Act) sets out the procedure that organisations providing health, care and social work services in Scotland are required, by law to follow when there has been an unintended or unexpected incident that results in death or harm to a person using our services.

Duty of Candour is one of the ways in which the Scottish Government's commitment to the provision of safe, effective and person-centred health and social care will be delivered. The aim and focus of the organisational Duty of Candour is promoting improvement in the provision of services delivered and learning lessons when things go wrong.

2. SCOPE

This procedure outlines the issues staff working in City of Edinburgh Council (hereafter referred to as 'the Council') care and social work services will consider at each point in the Duty of Candour Procedure, suggests best practice and provides a process map of steps to be taken to fulfil the duty.

In this guidance the word **must** refers to actions that are a legal requirement. The remainder of the guidance provides details of best practice when there has been an unintended or unexpected incident resulting in death or harm and provides specific detail:

1. Duty of Candour Procedure Triggers
2. Duty of Candour Identification
3. Duty of Candour Panel
4. Meaningful Apology
5. Duty of Candour Investigation Lead Officer Responsibilities

3. DEFINITIONS

Responsible Person – every organisation covered by the Duty of Candour legislation is regarded as a "responsible person" within the definition as set out in Section 25 of the Act.

Relevant Person – is the person who has been harmed during the incident. If this person lacks capacity or otherwise unable to make decision about the service provided, it is the person acting on their behalf (see section 22(3) of the Act). Or if they have died.

Registered Health Professional - a member of a profession to which section 60(2) of the Health Act 1999 applies. The Relevant Health Professional must not have had involvement in the incident but could be employed by the organisation.

Lead Officer – the person appointed to undertake the Duty of Candour investigation. This could be the officer appointed to undertake initial enquiries prior to the decision being made to activate the Duty of Candour.

4. ACTIONS

4.1 When should consideration be given to Duty of Candour?

The Council (as responsible persons) must activate the duty of candour procedure as soon as reasonably practicable after becoming aware that:

- an unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the Council;
- in the reasonable opinion of a registered health professional (as defined in Annex C, Scottish Government Organisational duty of candour: guidance) not involved in the incident:

(a) that incident appears to have resulted in or could result in any of the outcomes mentioned below; and

(b) that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

It is important to note that where the duty of candour procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for this has to be provided to the relevant person.

The relevant outcomes are as follows:

A. The death of the person.
B. Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm").
C. Harm which is not severe harm but which results in one or more of the following criterion:

- an increase in the person's treatment;
- changes to the structure of the person's body;
- the shortening of the life expectancy of the person;
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days;
- the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.

D. The person requires treatment by a registered health professional in order to prevent:

- the death of the person;
- any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph B or C.

See Duty of Candour Flowchart (appendix 1).

4.2 Where is the Duty of Candour most likely to be identified?

There are numerous existing Council processes, which will support the identification and activation of the duty of candour process. In some cases, this will be at the very first stage of reporting an incident to the Care Inspectorate and in others it may be during one of the following processes:

- Adult Support and Protection Procedures
- Child Protection Procedures
- Complaints handling
- Initial Case Reviews
- Significant Case Reviews
- Large Scale Investigations

4.3 What action is taken when an incident occurs that may meet Duty of Candour threshold?

The relevant manager of the service must complete and submit a **Significant Occurrence Notification** Form as soon as an incident which may meet the duty of candour threshold is identified. The Significant Occurrence Notification is completed in all circumstances – Registered & Non-Registered Services.

Managers of Council services registered with the Care Inspectorate will be asked if, when completing one of the following eForms, if the incident triggers the Council's duty of candour procedure:

- Accidents, incidents or injuries to a person using the service
- All deaths of a person using a care service
- Adverse event involving a controlled drug

Where duty of candour is identified in one of the processes outlined in section 4.2, the Chair will request that the manager of the service complete the Significant Occurrence Notification form, where this has not already been completed and if the service is registered, seek confirmation that an eform has been completed detailing the incident and duty of candour.

4.4 Significant Occurrence Notification Submission - Next Steps

Quality, Governance and Regulation will screen the Significant Occurrence Notification and verify that:

1. the Care Inspectorate have been notified where the involved service is registered
2. ascertain if the event meets the criteria for duty of candour outcomes (outlined in 4.1).

If the incident **does not** meet the threshold and is not subject to an ongoing Public Protection process, the Significant Occurrence Notification procedures commence.

If the incident **does not** meet the threshold and is subject to an ongoing Public Protection process, the case will be referred to the Chair/Lead Officer of the relevant Public Protection Group.

If the incident **does** meet the threshold the incident will be referred to the Council's duty of candour Review Panel.

The receipt of the duty of candour referral and the outcomes of screening will be recorded and held by the Quality, Governance and Regulation Service in accordance with Public Protection records retention protocols.

4.5 Duty of Candour Panel

The membership of the Council's Duty of Candour panel is as follows:
Chief Social Work Officer
Registered Health Professional (Tracey Gillies, NHS Medical Director or delegated other)
Relevant Head of Service

The decision to activate the duty of candour **must** be taken in conjunction with the Registered Health Professional. The legislation does not require this to be a detailed and comprehensive analysis of the incident to form an opinion about contributory factors. The requirement is for someone not involved in the incident to provide a view to inform a decision about activating the duty of candour procedure.

The Relevant Health Professional will require the following core information in the first instance:

- What was the incident?
- What was the outcome?
- What illnesses and underlying condition did/does the person have?

Information required from the Relevant Health Professional includes:

- Based on the background information provided, does it appear that this incident resulted in or could result in death or harm?

This document may be out of date if printed, the latest version is available on the Council Intranet.

- Does the natural course of the person's illness or underlying condition directly relate to the death or harm described?

In circumstances where there is not a registered health professional working within the organisation where the incident occurred (for instance a small care at home service or some social work services), registered health professionals with an existing involvement with the relevant person should be contacted where possible. However, they must not have been involved in the incident. Health services can provide assistance in identifying a registered health professional who would be able to provide the required view in such circumstances.

Although it is likely that the Council will already have a view on whether the procedure should be activated, the views of the Registered Health Professional not involved with the incident form an important further step in the duty of candour procedure. If the registered health professional thinks that it is unlikely that harm will occur, then the duty of candour procedure need not be activated for that incident. Confirmation of the activation of the duty of candour will be sent to the relevant Head of Service or the Public Protection Lead officer and the Quality, Governance and Regulation Service by the Health Professional.

Upon receipt of this email the Head of Service or Lead for the Public Protection Committee or Partnership will:

1. Write out to the relevant person apologising for what has happened (see appendix 2), to confirm the activation of the Council's duty of candour and advise that a formal investigation will commence
2. Appoint a lead officer/ single point of contact to undertake the duty of candour investigation on behalf of the Council.

4.6 What is the Duty of Candour procedure start date?

The procedure start date is the date that the Council receives confirmation from a registered health professional (Tracey Gillies, NHS Medical Director) that, in their reasonable opinion, an unintended or unexpected incident appears to have resulted in, or could result in an outcome listed above and that relates directly to the incident rather than to the natural course of the relevant person's illness or underlying condition.

4.7 Notification

The duty of candour legislation states that the relevant person should be notified as soon as reasonably practicable, but it should be considered good practice to notify the relevant person within 10 working days of the procedure start date. **See Appendix 3- Duty of Candour Checklist Council Checklist.**

This notification can be by various methods including telephone, face to face or by letter. It is important to remember that where a duty of candour procedure start date

is more than a month after the incident, the Council must provide the relevant person with an explanation for this.

4.7.1 Things to consider

Before having the conversation at the point of notification, the Council may wish to consider:

- Who from the Council is already in contact with the relevant person?
- What discussions or information exchange has already taken place?
- What is the relevant person's current understanding of the incident and organisational response to this?
- Where the conversation takes place?
- Who should be part of, and who should lead that conversation?
- What support should be available to the relevant person during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the relevant person?

The notification must include:

- an account of the incident to the extent that the Council is aware of the facts at the date the notification is provided; and
- an explanation of the actions that the Council will take as part of the procedure;

The Council should consider the support needs of relevant persons at the earliest possible opportunity and while following the duty of candour procedure.

4.8 Communication with relevant person

The Council Lead Officer must take reasonable steps to find out the relevant person's preferred method of communication. They must also take reasonable steps to ensure that communication with the relevant person is in a manner that they can understand.

If the Council Lead Officer is unable to contact the relevant person or the relevant person does not wish to speak with a nominated representative, the attempts made to contact them need to be included as part of the Council’s written record of the duty of candour procedure.

The Regulations do not permit or require the Council to disclose any information that would prejudice any criminal investigation or prosecution or contravene any restriction on disclosure arising by virtue of an enactment or rule of law.

Those acting on behalf of the Council should be mindful of its general obligations to act in accordance with the European Convention of Human Rights, and any other relevant laws relating to personal information.

4.8.1 What are the implications if a claim for compensation is made once the decision to follow the duty of candour procedure is made?

Whilst it would not be appropriate for any organisation to try to prevent the relevant person from making a claim, those acting on behalf of the Council can suggest to relevant persons that they may wish to wait until the duty of candour procedure has concluded, when their case will have been investigated; they will have received an apology; the facts will have been established and any actions to improve the quality of care and/or learning will have been identified.

If a relevant person mentions that they are considering making a claim, the duty of candour procedure should continue. If a relevant person makes a claim (i.e. the Council receives formal notification of commencement of legal proceedings), then some elements of the duty of candour procedure may need to be paused until the legal process reaches a conclusion. For example, internal reviews could still proceed and the Council should still try to identify any potential improvement and learning actions.

4.9 Apology

In addition to any apology provided at the time of the incident, as part of the duty of candour procedure the Council must offer the relevant person a written apology (this can be by electronic communication if that is the relevant person's preferred means of communication) in respect of the incident. **See Appendix 2 – Meaningful Apology.**

The written apology should be personal and be provided at an appropriate time during the duty of candour procedure, taking into account of the facts and circumstances in relation to the particular incident.

This should take account of the circumstances relating to the relevant person and, wherever possible, the known personal meaning or impact of the unexpected or unintended incident.

There may still be misconceptions and misunderstanding that the provision of an apology equates to an admission of liability and that organisations should never offer apologies for this reason – but that is not correct.

4.10 Meeting

The Council Lead Officer must invite the relevant person to attend a meeting and give them the opportunity to ask questions in advance. The Council Lead Officer must take reasonable steps to ensure that the meeting is accessible to the relevant person, having regard to their needs. In some circumstances it will be necessary to

have an interpreter, an advocate and/or someone the relevant person chooses to support them present.

Staff should try to avoid the use of jargon or explain technical terms when speaking with relevant persons.

4.10.1 The meeting must include:

- a verbal account of the incident;
- an explanation of any further steps that will be taken by the Council to investigate the circumstances which it considers led or contributed to the incident;
- an opportunity for the relevant person to ask questions about the incident;
- an opportunity for the relevant person to express their views about the incident; and
- the provision of information to the relevant person about any legal, regulatory or review procedures that are being followed in respect of the incident in addition to the procedure.

Following some unexpected or unintended incidents there may be several review processes operating in parallel. This can be confusing for people. To try to lessen this confusion, meetings with relevant persons must include details of other procedures which are being followed including their differing scope and focus.
In circumstances where there is concern, for example, that an unintended or unexpected incident was contributed to by factors influencing the capability of an employee, it may be helpful for the relevant person to know that in addition to the systems review in operation, a separate process has been put in place to identify whether an employee may benefit from support and/or consider matters not related to organisational review and learning.

4.10.2 After the meeting the relevant person must be provided with:

- a note of the meeting;
- contact details of an individual member of staff, or single point of contact acting on behalf of the Council who the relevant person may contact in respect of the procedure.

4.10.3 Things to consider

Make sure those acting on behalf of the Council agree with the relevant person what the note of the meeting will include. This does not need to be a verbatim account of the discussion but could include when and where the meeting took place, a record of the apology, actions and timescales agreed.

Make sure that this note of the meeting is shared in good time with the relevant person. In some instances where the note of the meeting is brief, it may then be

followed by a more comprehensive summary of the issues covered in the meeting – for example, outlining the questions that were asked or views expressed and the matters discussed.

If the relevant person does not wish to, or is unable to attend the meeting, the organisation must still provide them with the information set out above (other than a note of the meeting) if the relevant person wishes it.

4.11 Where more than one organisation needs to be involved in the Duty of Candour procedure

The duty of candour procedure is the legal responsibility of the organisation who provided a health service, care service or social work service where the incident occurred. Other health and social care providers may have been involved in the provision of care and services, but they are not responsible persons (organisations) in respect of that incident.

It is often the case that a range of organisations are involved in the episode of treatment or care where the unexpected or unintended incident occurred. Although they are not responsible persons in terms of the legislation, they may need to become involved in providing information as part of a review or in providing support for relevant persons coping with the personal impact of death or harm arising from the unintended or unexpected incidents. In rare circumstances, several responsible persons may each decide to activate the duty of candour procedure for multiple incidents. In such circumstances, responsible persons should seek to communicate with each other, emphasising co-operation and ensuring a co-ordinated approach in their communications with the relevant person.

Where more than one organisation needs to be involved in the duty of candour review, all parties are expected to co-operate fully throughout the duty of candour procedure and share lessons learned and necessary actions identified by the procedure.

Where this is the case, the relevant person must be informed as part of the notification process, that the organisation where the incident occurred is the responsible person, as defined by the legislation, who will carry out the procedure.

4.12 The review

The Council Lead Officer must carry out a review of the circumstances which they consider led or contributed to the unintended or unexpected incident. The legislation does not specify the manner in which the review is undertaken, but it is likely that this will be one of a range of review processes that are already undertaken such as an adverse event review, a significant case review, review undertaken by Public Protection committees/partnerships or a morbidity and mortality review, where they exist.

Best practice requires that reviews involve clinical and care professionals with the relevant subject matter expertise, as appropriate.

Best practice in reviewing unintended or unexpected incidents that have resulted in death or harm require that a systems emphasis is adopted. Useful resources on systems approaches include: Systems Analysis of Clinical Incidents (known as The London Protocol); Social Care Institute of Excellence's Learning Together model; and NHS Improvement Just Culture Guide.

In the case where the review is not completed within three months of the procedure start date, those acting on the Council's behalf must provide the relevant person with an explanation of the reason for the delay in completing the review.

In carrying out the review, the Council Lead Officer must seek the views of the relevant person and take account of any views expressed. This will be best implemented through the development of a supportive relationship with the relevant person and arrangements that are able to demonstrate the way in which these views (which are likely to reflect what matters most) have been taken into account.

4.13 The Council Lead Officer **must prepare a written report of the review, which must include:**

- a description of the manner in which the review was carried out;
- a statement of any actions to be taken by the Council to improve the quality of service it provides and share learning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services; and
- a list of the actions taken for the purpose of the procedure and the date each action took place.

This will provide the Council with an opportunity to demonstrate that the views of relevant persons have been considered and that a review has been conducted that has focused on systems analysis, taking account of best practice

The legal requirement to include details of the dates, when each element of the duty of candour procedure took place, is included to provide an overview of the process within an organisation from the point that they decide to activate the duty of candour procedure to the point the review is concluded.

The written report will be prepared using the Council's Duty of Candour Investigation Findings report template.

Where possible, written reports on reviews should be written in a manner that minimises the need for extensive redaction.

4.13.1 The Council Lead Officer **must offer to send the relevant person:**

- a copy of an executive summary or personalised letter;
- details of any further information about actions taken for the purpose of improving the quality of service provided by the Council or other health, care or social work services; and
- details of any services or support which may be able to provide assistance or support the relevant person or their family, taking into account their needs.

4.13.2 Things to consider

It is important to think about how the report of the review is written if it is to be shared with the 'relevant person'. It should not contain jargon or acronyms which are difficult to understand. It should be clear and understandable.

Review reports should include information on the actions that are to be taken to make improvements in systems and processes influencing the quality of care delivery. The actions taken to share learning with other organisations (such as those who might have similar organisational processes to the ones that formed the basis of the review) should be outlined in the written review report.

4.14 Records

The Council must keep a written record for each incident to which the duty of candour procedure is applied, including a copy of every document or piece of correspondence relating to the application of the duty of candour procedure to the incident. The written record should be retained by the Council in accordance with relevant local policies and procedures.

All documents, correspondence and written records associated with duty of candour cases will be retained within the Council's Public Protection records in line with retention protocols related with Significant Case Review.

4.15 Training

All staff working in Council care and social work services **must** develop an understanding of, and be able to identify what triggers, duty of candour. To support this, the Scottish Government, Health Improvement Scotland, the Care Inspectorate and the Scottish Social Services Council have developed a learning module, which can be accessed by registering with Turas https://learn.nes.nhs.scot/ and searching Duty of Candour eLearning, once registered https://learn.nes.nhs.scot/Scorm/Launch/2654 .

4.16 Reporting and monitoring

The Act sets out that the organisation providing health, care, or social work service during a financial year must prepare an annual report, as soon as reasonably practicable after the end of that financial year.

The Chief Social Work Officer's annual report meets the requirement of the Act and is published in a manner that is publicly accessible i.e. published on City of Edinburgh Council website.

The report, as required by the Act, will include:

- information about the number and nature of incidents to which the duty of candour procedure has applied in relation to a social work or social care service provided by the Council;
- an assessment of the extent to which the Council carried out the duty of candour;
- information about the Council's policies and procedures in relation to the duty of candour, including information about procedures for identifying and reporting incidents, and support available to staff and to persons affected by incidents;
- information about any changes to the Council's policies and procedures as a result of incidents to which the duty of candour has applied;

No individual, identifiable, information is to be contained in the Chief Social Work Officer's Annual Report.

Once the Council has published the report they must notify:

- Health Improvement Scotland
- The Scottish Ministers to dutyofcandour@gov.scot
- The Care Inspectorate

Healthcare Improvement Scotland, Scottish Ministers and The Care Inspectorate may, for the purpose of monitoring compliance with the duty of candour provisions, serve a notice on an organisation, requiring them to provide information about any of the matters listed in the Reporting and Monitoring section as specified in the notice, and that information is to be provided within the time specified in the notice. As a result, they may publish a report on the Council's compliance.

5. RESPONSIBILITIES

The Chief Social Work Officer has responsibility for the maintenance of this Procedure

Specific responsibilities are included in Section 4.

6. POLICY BASE

This procedure has been developed to implement the Duty of Candour Policy.

The Duty of Candour Policy has been developed in response to The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) introduced a new organisational duty of candour on health, care and social work services.

The procedure to be followed is set out in the Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) and came into effect on 1 April 2018.

7. ASSOCIATED DOCUMENTS

1. Significant Occurrence Notification form
2. Report Template

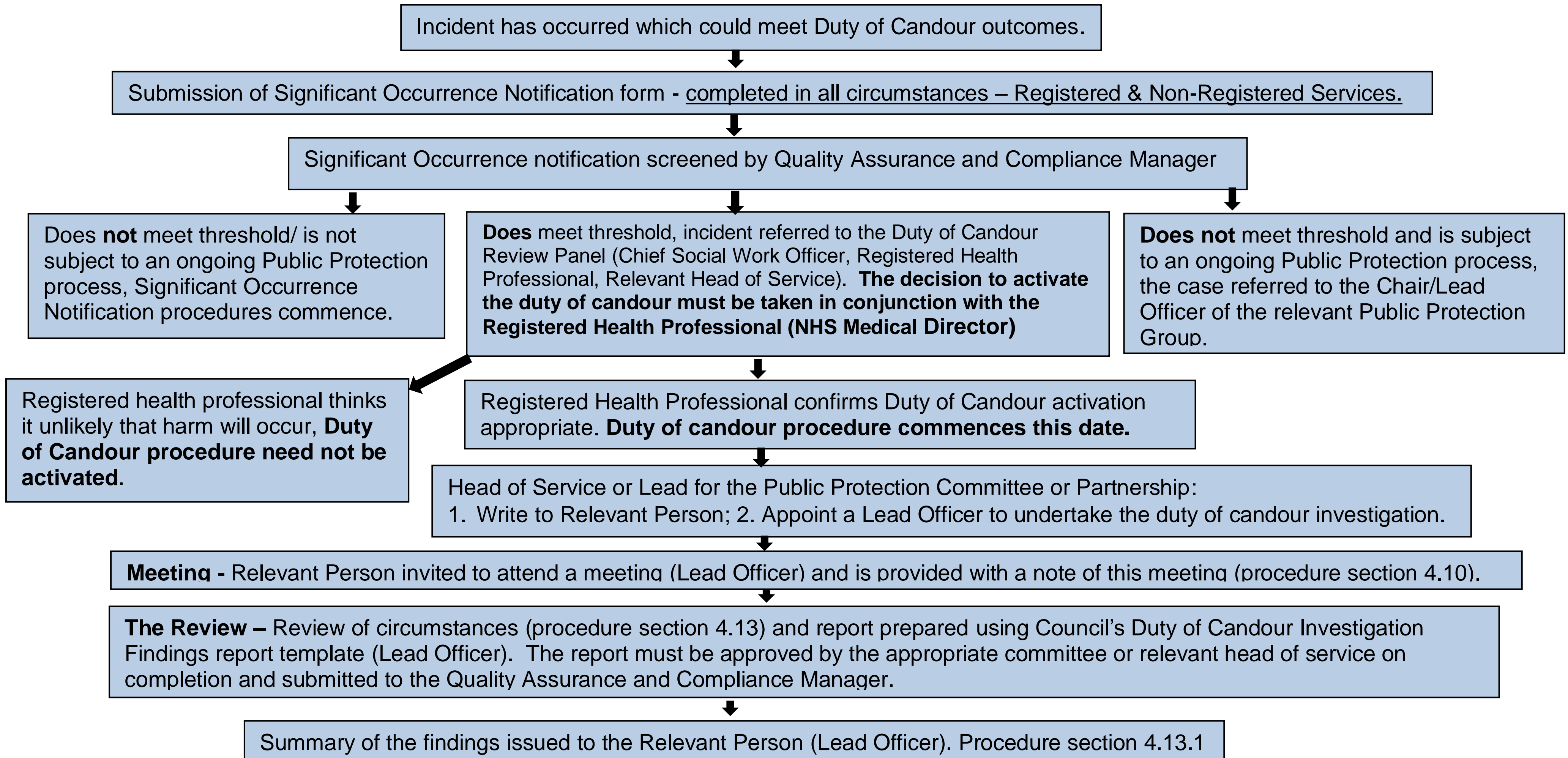
Professional regulators guidance: Scottish Social Services Council – Codes of Practice SSSC-codes-of-practice-for-social-service-workers-and-employers

8. RECORD KEEPING

When a procedure has been followed there are often outputs such as decisions made or events occurred that need to be recorded. These outputs are considered Council records. Please list all Records, including completed forms, generated by this procedure. For each record, list its title, location, responsible officer and minimum retention period.

Record Title	Location	Responsible Officer	Minimum Retention Period
Significant Occurrence Notification			
Duty of Candour Investigation Findings Report Template			
Duty of Candour Policy			
Duty of Candour Flowchart			

APPENDIX 1: DUTY OF CANDOUR FLOW CHART



APPENDIX 2 – MEANINGFUL APOLOGY

Making an apology
For the purposes of the Act, an "apology" means a statement of sorrow or regret in respect of the unintended or unexpected incident that caused harm or death. The Act sets out that an apology or other step taken in accordance with the duty of candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty.

Sometimes clinical and care staff find it difficult to say sorry when something has gone wrong and harm has occurred. People may be unclear if they can say sorry and worry that the timing for doing this will not be right or that they will make things worse. The Four Rs are an easy way to remember how we can get this right:

Reflect – stop and think about the situation.
Regret – give a sincere and meaningful apology.
Reason – if you know, explain why something has happened or not happened and if you don't know, say that you will find out.
Remedy – what actions you are going to take to ensure that this won't happen again and that the organisation learns from the incident.

It is important that an open and honest apology is provided from the outset as this can reassure an individual and/or their family and will also set the tone for moving things forward from here.

By making an apology following an unintended or unexpected incident, you are acknowledging that harm has been caused, a mistake has been made and you may be acknowledging emotions that are felt by the individual and/or their family. A meaningful apology can help to calm a person who has become angry or upset. An apology is not an admission of liability.

What is a meaningful apology?
An apology is often the first step in putting things right and can help to repair a damaged relationship and restore dignity and trust. To make an apology meaningful you should:

- acknowledge what has gone wrong;
- clearly describe what has gone wrong to show you understand what has happened and the impact for the person affected;
- accept responsibility or the responsibility of your organisation for the harm done;
- explain why the harm happened;
- show that you are sincerely sorry;
- assure the individual and/or their family of the steps you or the Council have taken, or will be taking to make sure the harm does not happen again (where possible);
- make amends and put things right where you can.

How should I make an apology?
Your apology should be based on the individual circumstances. There is no 'one size fits all' apology, but there are some general good practice points.

- the timing of the apology is very important and should be done without delay;
- to make the apology meaningful do not distance yourself from the apology or let there be any doubt that you or your organisation accept any wrongdoing;
- the language you use should be clear, plain and direct;
- your apology should sound natural and sincere;
- your apology should not question the extent of harm suffered by the person affected;
- your apology should not minimise the incident;
- it is very important that you apologise to the right person or people.

Who should apologise?

The Act states that the responsibility for the apology rests with the responsible person – this is the organisation delivering the service. Within each organisation there will be individuals with delegated responsibility for ensuring that the organisational duties (in this case providing an apology on behalf of the Council) are met (recognising that there are likely to have been individuals who have provided individual apologies).

For an apology to be effective it needs to be sincere. Sometimes you may need to apologise for an event which is not of your doing – indeed the organisationally focused apology required by the duty of candour procedure will involve this. Sometimes it is the official organisational recognition of the event that will be important to the individual and/or their family.

The timing of a more formal apology is at the discretion of the responsible person within the Council, but best practice would be to also apologise immediately the event comes to light. When making your apology you should not worry about who is to blame or what has gone wrong but merely apologise for the event occurring.

It is the responsible person's responsibility to make an apology, where appropriate, and you could include some phrases such as:
'I am sorry that this has happened to you and I'm going to find out what went wrong and come back to you.' 'I am sorry that harm has occurred, let me find out what has happened and come back to you with information.'

APPENDIX 3 – DUTY OF CANDOUR ORGANISATIONAL CHECKLIST

Step 1 Identifying and contacting the Relevant Person(s) • Do you know who the relevant person(s) is in relation to this incident? • Is their preferred method of contact already known? If not, this needs to be determined and noted. • Has it been possible to make contact with them? If not, a note should be made of the attempts to make contact. • Document in case record/file	
Step 2 Notifying the Relevant Person(s) • Provide the relevant person with an account of the incident and what actions are going to be taken (Note: If this is more than one month since the incident occurred the lead officer must explain the delay in the letter sent)	
Step 3 Arranging the first meeting • Organise a meeting with the relevant person(s) within 10 days of the duty of candour being activated. Provide the relevant person(s) with the opportunity and a documented process to ask questions in advance of the meeting	
Step 4 Meeting Format or via written communication if the invite to the meeting is declined • Explain to the relevant person(s) what happened • Explain what further steps are being taken • Provide an opportunity for the relevant person(s) to ask further questions • Provide an opportunity to enable the relevant person to express their views • Explain the links to other Council Public Protection processes • Provide a note of the meeting and details of an individual member of staff working for the Council who the relevant person may contact in respect of the procedure	
Step 5 Conducting the Investigation Note: Duty of Candour may progress in conjunction with other investigations/reviews such as Initial Case Review, Significant Case Review or Large-Scale Investigation • Seek the views of the relevant person(s) • Refer to the Health and Social Care Standards throughout in the investigation • Ensure that the focus on the investigation is on improving the quality of life for people using the service • Document learning throughout the process to support post investigation learning and changes to practice, procedures or policies • Document the actions taken in respect of the duty of candour • Throughout the process ensure that the nominated liaison officer / single point of contact provides support and assistance to the relevant person(s) • Ensure staff receive training and guidance on the duty of candour procedure as a way of giving context to the investigation • Ensure employees are provided with details of services (including Employee Assistance Programme) or support to help wellbeing	

Step 6 Concluding the Investigation • Document the findings of the investigation • Send confirmation and outcomes to the Chief Social Work Officer, Quality, Governance and Regulation Service and Head of Service. • Send a letter, summarising the findings of the investigation report, to the relevant person(s) (subject to appropriate information sharing) • Continue to update the relevant person(s) of actions taken after the investigation is concluded	

Sharing Learning

- The Child and Adult Protection Committee, Offender Management Committee and Equally Safe Partnership structures ensure that learning points are tracked and embedded into practice. For example, the close links between the Learning and Development and Quality Assurance subcommittees, with oversight from the Committees, ensures that where learning is identified this translates into practice change. Through monitoring actions until completion, these structures support us to make positive changes once learning is identified.
- Following learning, the Committee or Partnership have a range of strategies for sharing learning. This includes publishing staff briefings, which are routinely used at the conclusion of a Case Review and sharing these widely amongst multi-agency staff. These briefings are tools which promote learning and reflection on a pertinent topic.
- Bespoke learning events are developed and hosted, for example around emerging risks and the interagency training calendar is reviewed regularly to ensure it is current and relevant.